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ABSTRACT

The present study focused on therapist reports of their treatment goal priorities in working with children with sexual behavior problems. The study examined whether treatment goal priorities varied with therapist training and experience, and whether they reflected differences in the nature and seriousness of the youths' clinical problems. Results indicated there was significant variability in therapeutic emphasis among clinicians working with youth with sexual behavior problems, and that these variations were related to certain therapist and client variables. Specifically, direct emphasis on sexual behavior issues was related to training as a psychologist (as opposed to social worker), to co-morbid externalizing problems, and to therapist concern as to the chronicity of the sexual behavior problem. Generally speaking, therapist emphasis on symptom reduction (of any type) was related to clients suffering clinical levels of internalizing problems. (Author)

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Running head: GOAL PRIORITIES

Goal Priorities in Treatment of Youth Who Act Out Sexually*

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ABSTRACT

The present study focused on therapist reports of their treatment goal priorities in working with children with sexual behavior problems. The study examined whether treatment goal priorities varied with therapist training and experience, and whether they reflected differences in the nature and seriousness of the youths' clinical problems.

Results indicated there was significant variability in therapeutic emphasis among clinicians working with youth with sexual behavior problems, and that these variations were related to certain therapist and client variables. Specifically, direct emphasis on sexual behavior issues was related to training as a psychologist (as opposed to social worker), to co-morbid externalizing problems, and to therapist concern as to the chronicity of the sexual behavior problem. Generally speaking, therapist emphasis on symptom reduction (of any type) was related to clients suffering clinical levels of internalizing problems.

INTRODUCTION

Recent attempts to categorize sexual acting-out in childhood suggest that children exhibit a diverse array of problematic behaviors ranging from mildly problematic sexualized behaviors to aggressive sexual offending (Pithers, Gray, Busconi, & Houchens, 1998; Hall, Matthews, & Pearce, 2000). The significant heterogeneity of these behaviors present challenges to the development of effective treatment models. For example, clinicians must decide what level of emphasis to place in treatment on typical sexual offender treatment strategies such as confronting denial and minimization, identifying distorted cognitions or justifications, or providing sexuality education.

There is also growing evidence of significant co-morbid problems such as depression and conduct disorder, among youth who act out sexually (France & Hudson, 1993; Pithers et al., 1998). This further complicates the task of therapists in developing and focusing treatment plans for these youth.

HYPOTHESES

H_1 More experienced clinicians and those with doctoral level training would be more likely to focus treatment on:

(a) reduction of sexual behavior problems, (b) social and coping skills development..

H_2: Reduction of sexual behaviors would be emphasized more frequently in cases where indicators of serious sexual problems were present (i.e., penetration, multiple victims, repeat incidents)

H_3: Goals of reducing internalizing and externalizing symptoms would be emphasized more frequently when clinical levels of each respective symptom type present.

METHOD

Sample:

All youth in state custody screened by the child welfare department into specialized treatment for sexual behavior problems in Cook County, Illinois over an 18-month period were recruited for participation. (N = 120)

* Participation rate = 73%
* Age from 4-17 ($\bar{x}$ = 10)
* 61% male ; 39% female
* 77%African-American
* 4% Latino
* 6% Caucasian

Measures:

Data collection included chart reviews, in-home computer assisted interviews of youth and foster parent questionnaires.

Goal Priorities:

Therapists were asked to identify verbatim their most important and second most important short and long-term goals, resulting in opportunities for therapists to identify up to 4 different types of treatment goals. The therapist's responses were coded into 5 broad theoretically based categories:

1. Reduction of sexual behavior problems
2. Reduction of externalizing symptoms
3. Reduction of internalizing symptoms
4. Enhancement of the therapeutic relationship
5. Development of specific coping or social skills

Sexual Problem Behaviors:

Multiple sources of data were used to assess sexual behavior problems: (1) Child Sexual Behavior Inventory (Friedrich, 2001) was completed by the foster parent, (2) DCFS case screening records were reviewed and coded and (3) Therapist opinions were assessed via the phone survey.

Other Symptom Indices:

Measures of externalizing symptoms included:

- Psychopathy Screening Device (Child self-report)

  Callous and Impulsive subscales (Frick, 1992)

- Connors Parent Rating Scale (Caregiver report)

  Conduct Problems, Impulsive and Hyperactive subscales of (Connors, 1990)

Measures of internalizing symptoms included:

- Trauma Symptom Checklist (Child self-report)

  Anxiety, Depression, PTSD, Sexual concerns subscales (Briere & Runtz, 1989)

- Connors Parent Rating Scale (Caregiver report)

  Psychosomatic and Anxiety subscales

Table 1: Therapist Goal Priorities

	Priority Level (%)		
Short Term Goals	Top	2nd	Neither
Sexual Behavior Issues	35	13	52
Reduce Externalizing Symptoms	15	13	72
Skill Building	14	15	71
Reduce Internalizing Symptoms	11	3	86
Improve Therapeutic Relationship	7	3	90
Long Term Goals			
Sexual Behavior Issues	43	10	47
Reduce Internalizing Symptoms	28	3	69
Skill Building	10	17	73
Reduce Externalizing Symptoms	5	9	86
Improve Therapy Relationship	0	1	99

Table 2: Significant Effects of Clinician Variables on Goal Priorities

Clinician Variable	Short Term: Goal Priority 1 or 2		
Discipline (n=117)	Sexual Behavior Issues		
Ψ degree	52%		
SW degree	33%		6.399+ *
Education Level (n=77)	Reduce Externalizing Symptoms		
Doctorate	38%		
Masters	16%		4.760+ *
Clinician Variable	**Long Term: Goal Priority 1 or 2**		
Experience Level (n=119)	Skill Building		
	Yes	No	
Mean # Years	2.9	2.5	3.895# *

+ Chi^2 statistic; # F statistic; * $p < .05$

Table 3: Significant Predictors of Sexual Behavior Issues as a Treatment Priority

Variable	Short-Term Priority 1 or 2	
	% Yes	Chi-Square
Additional Sexual Incident +		
Yes	67	
No	43	4.937*
	Long-Term Priority 1 or 2	
	% Yes	Chi-Square
High Offense Risk +		
Yes	69	
No	47	4.391 *
Clinical Hyperactivity		
Yes	61	
No	42	4.105 *
Clinical Externalizing		
Yes	57	
No	21	6.324 *

+ Therapist report variable; * $p < .05$

Table 4: Clinical Symptom Levels Predicting Symptom Reduction as a Treatment Priority

Variable	Short Term Priority 1 or 2	Chi-Square
CPRS: Anxiety (n=120)	Reduce Internalizing Symptoms	
Yes	32%	
No	95%	8.259 *
CPRS: Psychosomatic (n=120)		
Yes	28%	
No	99%	5.664 *
	Long Term Priority 1 or 2	**Chi-Square**
Clinical Externalizing (n=119)	Reduce Internalizing Symptoms	
Yes	28%	
No	57%	5.026 *
Penetration (n=119)	Reduce Externalizing Symptoms	
Yes	30%	
No	10%	6.072 *
TSC: Sex Concerns (n=54)		
Yes	31%	
No	7%	4.812 *
TSC: PTSD (n=54)		
Yes	22%	
No	4%	4.103 *

RESULTS

No support was found for hypothesis 1a predicting effects of therapy experience and training level on the likelihood of sexual behavior problem emphasis. However, discipline of training did predict emphasis on sexual behavior, with those of the psychology discipline (master's and doctoral combined) being more likely to highly prioritize sexual behavior problem reduction than social workers. With respect to skill development goals, in support of hypothesis 1b, a higher level of therapist experience was associated with long term emphasis on skill development. In addition, doctoral level clinicians were more likely to prioritize reduction of externalizing problems in the short-term.

Regarding our second hypothesis, there was evidence of linkage between the severity of sexual problems and the likelihood of therapists making sexual behavior problem reduction a high priority treatment goal (see Table 3). Both therapist reports of repeat sexual incidents in the first six months after the problem was first identified, and therapist estimates of risk for repeat offending predicted emphasis on sexuality goals (in the short and long term, respectively). Interestingly, sexual problem reduction was also more likely to be a high priority long-term treatment goal in cases exhibiting clinical levels of hyperactivity and overall externalizing symptoms.

The association that we expected between clinical levels of externalizing symptoms and a treatment focus on reducing those symptoms was not supported (hypothesis 3). Instead, incidents involving penetration and higher scores on two internalizing symptom scales of the TSC were associated with therapist focus on long term reduction of externalizing problems (see bottom of Table 4).

As predicted, therapist emphasis on reducing internalizing symptoms was linked (in the short-term) with clinical levels of two Connors internalizing symptoms scales (see

top of Table 4). Also, long-term emphasis on internalizing symptoms was associated with the absence of clinical levels of externalizing symptoms and low scores on the callousness subscale of PSD (last effect not in table).

Lastly, with respect to long term skill development, non-clinical levels of impulsivity and depression on the PSD and TSC measures respectively, were significant predictors (not shown in tables).

DISCUSSION

Surprisingly, in nearly 30% of the current sample, therapists did not prioritize explicit work on reduction of the sexual behavior problem as a short or long term treatment goal. Another surprising null result was that chart review data on the level of severity of the sexual incident (i.e., penetration vs. genital contact vs. non-genital fondling) that prompted screening for specialized treatment was not associated with the likelihood that therapists would emphasize sexual behavior problem reduction as a treatment goal. However, therapist's own reports of repeat sexual incidents after screening and assessments of higher risk were associated with greater treatment emphasis on sexual behaviors in the short-term. Although goal planning may be associated with sexual behavior severity, there may have been poor correspondence between the initial screening data and subsequent assessments of sexual behaviors and problem severity.

Our data suggests that emphasis on sexual behaviors may be equally linked to non-sexual behavior problems as well as the presenting problematic sexual behavior. One possible explanation for this is that some therapists may believe it is necessary to first attend to the other behavior problems and then address sexuality in the long-term. Therapists also demonstrated responsiveness to treatment planning of internalizing symptoms as reported by foster parents.

In this sample, emphasis on skill development in treatment was associated with therapist experience level as well as clients who self-reported less impulsivity and depression. This suggests that client mood and inattentiveness and therapist

inexperience may be important barriers to overcome in any treatment model that emphasizes social and coping skill enhancement.

The limitations of the present analyses include elevated type I error associated with using multiple indices for testing each hypothesis and limited sample size and power to explore dividing the sample according to gender and age range.

A detailed progress report of the
Children with Sexual Behavior Problems Longitudinal Study
is available by contacting Steve Spaccarelli, Ph. D. at:
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